DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445419	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OVERTON COUNTY NURSING HOME	318 BILBREY STREET LIVINGSTON, TN 38570

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the annual recertification survey conducted on April 9 - 11, 2012, At Overton County Nursing Home, complaints #TN00029104 and #TN00029445 were investigated. No deficiencies were cited for the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to obtain a Physician's Order to discharge one resident (#1) from Hospice and to follow Physician's Orders for anti-embolism/compression stockings (TED hose) for one resident (#10) of twenty-nine residents reviewed. The findings included: Resident #1 was admitted to the facility on March 11, 2011, with diagnoses including Obstructive Hydrocephalus, Senile Dementia, Alzheimer's Disease, Urinary Retention, and Hypertension. Medical record review of the Minimum Data Set dated January 19, 2012, revealed the resident required minimal assistance with decision making, had no problem with memory, required total assistance with transfers, and all activities of daily living.	F 281	The order was obtained from the MD and a telephone order written to d/c resident #1 from Hospice. Upon evaluation of a Resident receiving Hospice services if the Hospice provider determines to discharge the resident then the Hospice nurse receiving the order from the physician and the facility nurse will sign the telephone order together to assure that the information is correct and both parties are aware of the imminent discharge and date of discharge from Hospice services.	4/11/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 5/1/2012

(X4) deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 Observation on April 9, 2012, at 10:30 a.m., in the resident's room, revealed the resident sitting in a...(brand name) chair with leg support straps around the resident's thighs, for support. Medical record review of a Hospice Recertification Visit Note dated January 25, 2012, revealed, "...cognitive disability continues with confusion and delusions, but no apparent decline at this time. No physical decline at time of visit. Recommend discharge from Hospice." Medical record review revealed the last Hospice visit was January 25, 2012. Interview with the Administrator of the ...(Local) Hospice Center on April 9, 2012, by phone, at 2:25 a.m., revealed, the resident had been discharged from Hospice on February 2, 2012. Medical record review of the Physician's Orders from January 31, 2012, through April 9, 2012, revealed no documentation of a discharge order from Hospice. Interview with Registered Nurse #1, on April 10, 2012, at 8:00 a.m., in the conference room, confirmed the facility had failed to write a Physician Order to discharge the resident from Hospice on February 2, 2012 Resident #10 was admitted to the facility on October 29, 2010, with diagnoses including Cerebrovascular Accident with Right-sided Weakness, Chronic Back Pain, Senile Dementia, Osteoarthritis, Hypertension, Chronic Obstructive Pulmonary Disease and Chronic Right Shoulder	F 281	The Hospice Case manager will audit all Hospice charts of residents on a weekly basis to maintain that the orders for discharge are present with two nurses signatures, one from the Hospice nurse and one nurse from the facility. The Regional Hospice Case Manager will address discharges at the monthly meeting with facility members and the facility charge nurses to clarify questions on discharges, and discharge orders. A meeting was held with the Hospice case manager, regional manager, Social worker, and facility staff (DON, QA nurse, Wound Care Coordinator, MDS nurse, SocialWorker, Activity Director, and floor charge nurse) to pass the Information to them and to clarify all physician orders with Hospice residents on 4/11/2012.	4/19/2012

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F 281	Continued From page 2 Pain. Medical record review of the Physician's Orders for the month of April 2012, revealed "...Ted (Anti-embolism/compression) Hose while up check q (every) shift d/t (due to) BLE (bilateral lower extremity) edema (swelling) Start Date: 5/26/11..." Observation of the resident on April 10, 2012, at 1:15 p.m., in the resident's room, revealed the resident sitting in a recliner with the feet dangling, wearing white ankle socks, white tennis shoes and not wearing TED Hose. Interview with Certified Nursing Assistant (CNA) #1 on April 11, 2012, at 8:50 a.m., at the Wing 3 Nurse's station, revealed the resident wore TED Hose "at one time but I don't know what happened to them. It's been a while since (the resident) has worn them." Observation and interview with Licensed Practical Nurse (LPN) #3 on April 11, 2012, at 9:05 a.m., in the resident's room, confirmed the resident was sitting in a recliner with the feet dangling and not wearing TED Hose. Observation and interview with LPN # 3 on April 11, 2012, at 9:15 a.m., in the resident's room, confirmed the resident sat in a recliner the majority of the day with the feet dangling and had not been wearing TED Hose. Continued interview confirmed the resident's lower legs were swollen and the Physician's order for TED Hose had not been followed.	F 281	Resident # 10 Does have extra TED hose in her room so as one pair becomes soiled, another can be applied daily. Orders are in the EMAR system for the licensed staff to check these daily. QA nurse will monitor the EMAR and nurse checking off on the TED hose through her quarterly audits of MARS. The Quarterly QA meeting will cover the compliance of following physician orders for all residents. Random audits by the QA nurse and night shift RNs will occur weekly to assist in monitoring compliance.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 3 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure communication between the dialysis center and the facilitiy occurred to assure quality care for two resident's (#14 & #27) of twenty-nine resident's reviewed. The findings included: Resident #14 was admitted to the facility on March 9, 2012, with diagnoses including End Stage Renal Disease, Vascular Dementia, Hypertension, Cerebral Artery Occlusion, Diabetes Mellitus, Acute Myocardial Infarction, Atrial Fibrillation and Renal Dialysis. Medical record review of resident #14 Care Plan, on April 10, 2012, at 2:50 p.m., revealed the resident was scheduled for dialysis on Monday, Wednesday and Friday and the resident's family transported the resident to the dialysis center and back to the facility. Further medical record review revealed no documentation from the facility or from the dialysis center regarding the resident's plan of care or current status.	F 309	Resident #14 receives dialysis 3x a week. Licensed nursing staff will send the communication form with the resident on days for dialysis or care from outside providers. The facility will request that any outside provider fill out the information on medications, vitals and any pertinent issues while the resident is out of facility receiving care. This form will return with the resident and go in their permanent record. If the outside provider does not send the form upon the resident's return to facility they may fax it back to the facility. The charge nurse will check on return of the resident. (This form would not be used for hospitalization because we will receive report from the admit nurse)	4/19/2012

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F 309	Continued From page 4 Interview with Licensed Practical Nurse (LPN) #9, on April 10, 2012, at 2:50 p.m., in the 4 Wing Nurses Station, revealed the facility did not send information with the resident to the dialysis center. Further interview confirmed the dialysis center did not send information regarding the resident's dialysis status, labs, or medications given at the facility, after the procedure. Continued interview revealed "...the dialysis center would call us if there were any issues..." Interview with the Director of Nursing (DON) on April 10, 2012, at 3:20 p.m., in the DON office, confirmed the facility did not have a policy regarding communication between the facilities and no written communication was sent to the facility or received back from the dialysis center. Continued interview revealed "they (dialysis) would call us if there were any issues and normally we do not have any issues". Resident #27 was admitted to the facility on March 27, 2012, with diagnoses including End Stage Renal Disease with Renal Manifestations, Hypertension, Hyperkalemia, Anemia, Panic Disorder and Legal Blindness. Medical record review on April 11, 2012, revealed the resident was scheduled for dialysis on Monday, Wednesday and Friday. Further review revealed no documentation from the facility or from the dialysis center regarding the resident's plan of care or current status. Interview on April 11, 2012, at 9:30 a.m., with Licensed Practical Nurse (LPN) #10, in the 2 Wing Nurses Station, confirmed the facility did not send information to the facility with each	F 309	A policy and procedure is In place for the communication between providers. An in service was held on 4/19/2012 passing this info to licensed staff and transfer aides to increase information sharing and compliance. The QA nurse will follow up on the information papers to have compliance and contact outside providers as needed. This will be monitored by the QA nurse and the QA meetings for compliance.	4/19/2012

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F 309	Continued From page 5 procedure and the dialysis center did not send written information, labs, or medications given at the dialysis facility, back to the facility regarding the current dialysis procedure.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure use of a chair alarm for one resident (#4); failed to ensure two person assistance and use of a gait belt for one resident (#12); and failed to ensure use of padding to side rails for one resident (#13) of twenty-nine residents reviewed. The findings included: Resident #4 was admitted to the facility on January 9, 2003, with diagnosis of Recurring Psychosis-Mild, Coronary Arthrosclerosis , Hypertension, Iron Deficient Anemia, Joint Pain, Chronic Ischemic Heart Disease, Coronary Artery Bypass Graft, Angina Pectoris, and Diaphragmatic Hernia. Medical record review of the Minimum Data Set dated February 16, 2012, revealed the resident	F 323		

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F 323	Continued From page 6 had severely impaired cognition, required supervision for transfers and ambulation, and a history of falls. Medical record review of the Fall Risk care plan dated April 3, 2012, revealed " ...Pressure release chair alarm while up. Move to bed when in bed ..." Medical record review of a Nurse's Note dated April 1, 2012, at 11:40 a.m. revealed the resident had been found lying on the floor, on the resident's left side, next to the window near the heating unit, and had a skin tear to the upper left forearm. Observation of the resident on April 10, 2012, at 8:25 a.m., in the resident's room, with Certified Nurse Assistant (CNA) #1 revealed the resident was sitting up in the chair, the pressure release alarm mat was in the bed, not in the chair. CNA #1 confirmed the sensor mat was to be transferred to the chair when the resident was in the chair. Interview with Registered Nurse (RN) #1 on April 10, 2012, at 9:31 a.m., in the basement hallway confirmed the sensor alarm mat was to be in the chair when the resident was in the chair, and stated " ...a separate sensor mat would be added to the chair because the sensor mat was required when the resident was in the chair ...". Resident #12 was admitted to the facility on June 30, 2011, with diagnoses including Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Legally Blind, and Osteoarthritis. Medical record review of a Fall Risk Assessment	F 323	Resident # 4 has an alarm for bed and chair. The order was clarified and both safety items in place. The RN that investigates falls will contact the MD and write the alarm orders as indicated. The RN will check the care plans to ensure that the order and care plan match in the care that is being performed for the resident. The QA nurse and RN on evenings will incorporate alarms and care plans in the audit process to make sure they match. The QA nurse will evaluate the orders quarterly to assure compliance.	4/19/2012

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F 323	Continued From page 7 last updated on March 6, 2012, revealed the resident had impaired vision, had a decrease in lower extremity strength, had difficulty in rising, and was unable to balance while standing. The Fall Risk Assessment revealed the resident was given a falls risk score of twenty, indicating the resident was at high risk for falls. Medical record review of a Nurses notes dated March 28, 2012, revealed "...res (resident) stood up...lost balance...fell to floor...rib pain to right side..." Medical record review of a Plan of Care last reviewed on March 28, 2012, revealed "...risk for falls R/T (related to) balance disturbances...hx (history of) falls...two person transfer & (and) ambulation c (with) gait belt..." Observation and interview on April 10, 2012, at 9:55 a.m., revealed the Activities Director (AD) assisting the resident with a rolling walker back to the resident's room. Continued observation revealed the AD standing at the foot of the resident's bed next to the rolling walker while the resident walked unassisted from the foot of the bed to the left side of the bed and positioned self on the bed. Continued interview with the AD confirmed, the resident "usually transfers by (her/him) self...if not a long distance...gets around okay." Interview with Certified Nursing Assistant (CNA) #3 on April 10, 2012, at 10:05 a.m., on the Wing 3 hallway, confirmed the resident "usually uses a gait belt" with one person assistance for transfers and ambulation.	F 323	Resident # 12 has Had an improvement in condition yet the care plan did not reflect it correctly and the staff was not following the physician order. The resident is now a 1 Person assist as needed and restorative nursing has the resident for ambulation. Upon review of the resident care plans, the DON and QA nurse will match the resident for ADL changes. If these are noted in the MDS (section G, ADL question) then Restorative nursing and Therapy will be notified of the change for evaluation and treatment as indicated. This will be performed biweekly. The MD will be contacted with changes and orders received to meet the resident's needs. Evaluation of this will be Done with the MDS updates And with the QA quarterly meetings.	

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F 323	Continued From page 8 Interview with Registered Nurse (RN) #1 on April 10, 2012, at 9:30 a.m., at the Wing 4 nurses station, confirmed "when an event occurs on a unit the staff working at that time are in-serviced, but other staff and departments receive the information by word of mouth...there is an in-service notebook...other departments may not read it...we need to do better." Resident # 13 was admitted to the facility on August 18, 2008, with diagnoses including Hypothyroidism, Aortic Valve Disorder, History of Cerebral Vascular Accident (Stroke) with Left Side Hemiplegia (paralysis), Depression, Mental Decline, Anxiety, Dementia, History of Aspiration Pneumonia, and Meniere's Syndrome. Medical record review of the Minimum Data Set (MDS), dated March 14, 2012, revealed the resident had severe impaired cognition with loss of short and long term memory and required total assistance with Activities of daily living (ADLs). Medical Record review of the Care plan, dated March 3, 2012, revealed " ...sheepskin to bedrails for safety ...". Observation of the resident's room on April 9, 2012 at 9:30 a.m., revealed a sheep skin cover with straps tied to the base of the resident's bed, and the sheepskin lying on the floor. Observation and interview with Certified Nurse Aide (CNA) #3 on April 10, 2012, at 1:35 p.m., in the resident's room, confirmed the sheep skin was attached to the base of the resident's bed and the sheepskin was lying on the floor. Further interview confirmed the sheepskin was to be	F 323	Resident # 13 has order for sheepskin to bed rails. The sheepskin is applied to side rails. The nursing staff received in service on 4/19/2012 on following physician orders and devices for safety and comfort of the residents. The QA nurse will perform visual audits on wings on a monthly basis to check application of safety devices and comfort items for residents. This is a plain check off yet the QA committee will find the areas needing improvement and can address what can be done on an immediate basis for compliance. The QA nurse will monitor compliance at the quarterly QA meetings.	

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F 323	Continued From page 9 attached to the side rail to prevent bruising. Further observation revealed CNA #3 left the room without placing the sheepskin on the side rail. Observation and interview with Licensed Practical Nurse (LPN) #4 on April 10, 2012, at 1:45 p.m. in the resident's room, confirmed the sheep skin was lying on the floor with the strap attached to the base of the resident's bed frame and was to be attached to the side rails at all times. Continued observation of the resident's legs with LPN #4 revealed "a large bruise approximately 6 X 7 centimeters" on the top of the resident's left foot and multiple bruises on the legs and shins "in various stages of healing ..." LPN #4 confirmed the resident was prone to frequent bruising due to "agitation and flailing about" when care was being performed. Interview with LPN #6 on April 11, 2012, at 9:15 a.m., at the Wing 3 nurses station confirmed sheepskins were to always be on the resident's side rails for protection from bruising.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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F 431	Continued From page 10 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of manufacturer's specifications, and interview, the facility failed to provide biologicals used for resident glucose testing with acceptable expiration dates on four (Wing 1 Medication Cart, Wing 2 Medication Cart 1, Wing 3 Women Medication Cart, and Wing 4 Medication Cart) of six medication carts observed. The findings included: Wing 1 Medication Cart	F 431		

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F 431	Continued From page 11 Observation of the Wing 1 Medication Cart, on April 9, 2012, at 10:20 a.m., at the Wing 1 Nursing Station, with Licensed Practical Nurse (LPN) #1, revealed one Assure 4 Control Solution box containing one, 2.5 milliliter (ml) bottle of Level 1 Glucose Testing Solution and one, 2.5 ml bottle of Level 2 Glucose Testing Solution. Further observation revealed the bottles were opened without the documentation of an opening date on each bottle. Review of the manufacturer's specifications in the package insert inside the box of Assure 4 Control Solution revealed, Level 1 and Level 2 Glucose Testing Solutions are "...For use...as a quality control check to verify the accuracy of blood glucose test results..." in diabetics "...Use the control solution within 90 days (3 months) of first opening..." Review of the manufacturer's specification on the box of the Assure 4 Control Solution revealed, "...Record the date the solution was opened on the bottle label...Do not use if expiration date has passed...Use within 90 days after first opening..." Interview with LPN #1 on April 9, 2012, at 10:25 a.m., at the Wing 1 Medication Cart, in the Wing 1 Nursing Station, confirmed the opened bottles of glucose test solutions for verifying the accuracy of resident blood glucose test results were not dated when opened. Wing 3 Women Medication Cart Observation of the Wing 3 Women Medication Cart, on April 9, 2012, at 12:30 p.m., at the Wing 3 Nursing Station, with LPN #4, revealed one	F 431	The facility has a supervisor over the supply department. The supervisor will supply the glucose testing solution and date it as she distributes it. The supply supervisor will replace and date these by the manufacturer recommendation of every ninety days. This will be done on all facility floors each ninety days. The QA nurse will check these Quarterly with the QA Audit and the QA committee will be informed of issues of noncompliance.	4/12/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445419	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 12 Assure 4 Control Solution box containing one, 2.5 ml bottle of Level 1 Glucose Testing Solution and one, 2.5 ml bottle of Level 2 Glucose Testing Solution. Further observation revealed the box was dated as opened on January 1, 2012, and the opened bottles of glucose test solutions for verifying the accuracy of patient blood glucose test results were not dated when opened. Review of the manufacturer's specifications in the package insert inside the box of Assure 4 Control Solution revealed, Level 1 and Level 2 Glucose Testing Solutions are "...For use...as a quality control check to verify the accuracy of blood glucose test results..." In diabetics "...Use the control solution within 90 days (3 months) of first opening..." Review of the manufacturer's specification on the box of the Assure 4 Control Solution revealed, "...Record the date the solution was opened on the bottle label...Do not use if expiration date has passed...Use within 90 days after first opening..." Interview with LPN #4, on April 9, 2012, at 12:35 p.m., at the Wing 3 Women Medication Cart, in the Wing 3 Nursing Station, confirmed the glucose test solutions for verifying the accuracy of resident blood glucose test results were expired after April 1, 2012, and the bottles were not dated when opened. Wing 4 Medication Cart Observation of the Wing 4 Medication Cart, on April 9, 2012, at 1:15 p.m., at the Wing 4 Nursing Station, with LPN #7, revealed one Assure 4 Control Solution box containing one, 2.5 ml bottle	F 431		

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F 431	Continued From page 13 of Level 1 Glucose Testing Solution and one, 2.5 ml bottle of Level 2 Glucose Testing Solution. Further observation revealed the bottles were opened without the documentation of an opening date on each bottle. Review of the manufacturer's specifications in the package insert inside the box of Assure 4 Control Solution revealed, Level 1 and Level 2 Glucose Testing Solutions are "...For use...as a quality control check to verify the accuracy of blood glucose test results ..." in diabetics "...Use the control solution within 90 days (3 months) of first opening..." Review of the manufacturer's specification on the box of the Assure 4 Control Solution revealed, "...Record the date the solution was opened on the bottle label...Do not use if expiration date has passed...Use within 90 days after first opening..." Interview with LPN #7 on April 9, 2012, at 1:20 p.m., at the Wing 4 Medication Cart, in the Wing 4 Nursing Station, confirmed the opened bottles of glucose test solutions for verifying the accuracy of resident blood glucose test results were not dated when opened. Wing 2 Medication Cart 1 Observation of the Wing 2 Cart 1 Medication Cart, on April 9, 2012, at 2:40 p.m., at the Wing 2 Nursing Station, with LPN #8, revealed one Assure 4 Control Solution box containing one, 2.5 ml bottle of Level 1 Glucose Testing Solution and one, 2.5 ml bottle of Level 2 Glucose Testing Solution. Further observation revealed the bottles were opened without the documentation of an	F 431		

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F 431	Continued From page 14 opening date on each bottle. Review of the manufacturer's specifications in the package insert inside the box of Assure 4 Control Solution revealed, Level 1 and Level 2 Glucose Testing Solutions are " ...For use...as a quality control check to verify the accuracy of blood glucose test results..." In diabetics "...Use the control solution within 90 days (3 months) of first opening..." Review of the manufacturer's specification on the box of the Assure 4 Control Solution revealed, "...Record the date the solution was opened on the bottle label...Do not use if expiration date has passed...Use within 90 days after first opening ..." Interview with LPN #8 on April 9, 2012, at 2:45 p.m., at the Wing 2 Medication Cart 1, in the Wing 2 Nursing Station, confirmed the opened bottles of glucose test solutions for verifying the accuracy of patient blood glucose test results were not dated when opened.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 15 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to ensure appropriate signage was on isolation rooms for four (#6, #23, #24, #25) of five isolation rooms observed and failed to ensure patient items were separated from contaminated items for one (#9) of twenty-nine residents reviewed. The findings included: Medical record review revealed resident #6 was	F 441	The correct signage has been ordered and immediate signage was placed on isolation rooms #6, # 23,#24 and #25. The policy was already in place et the signs were removed at some point. An inservice was given On 4/19/2012 to licensed nursing staff over this topic and licensed nursing is responsible for placing the correct signage when they receive a physician order to place a resident on isolation. The QA nurse will incorporate observation for compliance in the biweekly floor QA compliance rounds. The QA committee will meet quarterly to discuss issues with compliance on isolation residents.	4/19/2012

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F 441	Continued From page 16 admitted to the facility on March 28, 2012, with diagnoses to include Chronic Obstructive Pulmonary Disease, Hypertension, and Alcohol Dementia. Continued record review revealed the resident had a wound to the left great toe which was cultured as Methicillin Resistant Staphylococcus Aureus - multi drug resistant organism (MRSA). Observation of the resident's room on April 9, 2012, at 10:30 a.m., during initial facility tour, revealed a cart of personal protective equipment outside the room; biohazard linen and trash containers in the room; but no door sign to alert visitors the resident was on isolation. Medical record review revealed resident #23 was admitted to the facility on March 23, 2012, with diagnoses to include Rectal Prolapse, Hypertension, Gastroesophageal Reflux Disease, and Anemia. Continued medical record review revealed the resident had MRSA cultured from sputum. Observation of the room on April 9, 2012, at 10:40 a.m., during initial facility tour, revealed a cart of personal protective equipment outside the room; biohazard linen and trash containers in the room; but no door sign to alert visitors the resident was on isolation. Medical record review revealed resident #24 was admitted to the facility on July 14, 2008, and readmitted on March 27, 2009, with diagnoses to include Atrial Fibrillation, Diabetes Mellitus, Hypertension, and Leg Ulcer. Continued medical record review revealed the resident had MRSA in the urine.	F 441		

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F 441	Continued From page 17 Observation of the resident's room on April 9, 2011, at 10:50 a.m., during initial facility tour, revealed a cart of personal protective equipment outside the room; biohazard linen and trash containers in the room; but no door sign to alert visitors the resident was on isolation. Medical record review revealed resident #25 was admitted to the facility on August 21, 2011, with diagnoses to include Parkinson's Disease, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Transient Ischemic Attack, and Bipolar Disorder. Continued record review revealed the resident had MRSA in the sputum. Observation of the resident's room on April 9, 2012, at 10:55 a.m., during initial facility tour, revealed a cart of personal protective equipment outside the room; biohazard linen and trash containers in the room; but no door sign to alert visitors the resident was on isolation. Review of the facility policy entitled Isolation Techniques, NP - II - 16, revealed "...Isolation signs should be placed on the door of rooms where residents receive isolation precautions. The sign should inform visitors "Do not enter room. Report to the Nurses' Station for instructions...". Interview on April 10, 2012, at 9:30 a.m., on the Wing IV Hall, Registered Nurse #1 confirmed there were no signs on the residents' room doors to indicate the residents were on isolation and visitors needed to report to the nurses' station.	F 441		

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F 441	Continued From page 18 Resident #9 was admitted to the facility on June 23, 2004 and re-admitted to the facility on October 27, 2010 with diagnoses including Alcoholic Cirrhosis, Degenerative Disc Disease, Chronic Obstruction Pulmonary Disease, Diabetes, Arthritis, and Chronic Pain. Reiyew of the Minimum Data Set dated January 5, 2012 revealed the resident to be moderately cognitively impaired and required assistance with activities of daily living. Observation on April 9, 2012 from 12:55 p.m. until 1:10p.m., in the resident's room, revealed the resident lying on the bed with a pressure pad alarm system in place. Observation reveald the alarm cord extending off the pressure pad on the bed with the alarm device affixed to the resident's trash can which was positioned behind the head of the bed. Continued observation revealed the trash can contained several pairs of soiled vinyl gloves and the clip to the alarm was in contact with the soiled gloves inside the trash can. Interview with Licensed Practical Nurse #2 on April 9, 2012 at 1:10 p.m. in the resident's room confirmed the alarm was not to be affixed to the trash can.	F 441	The body alarm has a bag in place. Velcro bags to attach to rails and wheel chairs are available on the wound care cart, in restorative closet and the QA nurse has additional ones in her office. The QA nurse will include placement of alarms in her biweekly compliance rounds. The QA committee will address the infection control issue in the quarterly QA meeting.	4/19/2012